River Region Cardiology

185 Mitylene Park Lane Montgomery, AL 36117
334-387-0948 Office 334-387-0955 Fax

HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Name_____ Date of Birth_____

Social Security #_____

I hereby authorize the release of any information pertaining to my care, including diagnosis and medical records of any treatment or examination to me.

AUTHORIZATION FROM:

_____

RELEASED TO: (Person/Organization receiving the information):

River Region Cardiology, 185 Mitylene Park Lane, Montgomery, AL 36117

Purpose of the release:

- Continued Medical Care
- Other (Please Specify): Transfer of Records

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. IF I have authorized the information to a receipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclosure it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for 365 days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that had already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand that I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date